Section 6. Strengthening the educational potential of small-group work: implications from the evaluation

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I wouldn't necessarily expect to see any effects for about ten years! It's an evolutionary process. . . . It's very difficult to make any assessment of how well we're doing. Reality isn't clear-cut. If I disturb them, then I've done my job.

(Dr Scorso)

In this Section we return to our key research questions:

- *What does a Balint approach to small-group work in VTS provide?*
- *Given the likely complexity of the learning process, how was effectiveness to be gauged? What did effectiveness mean in this context?*
- *What wider lessons might an intensive analysis of a Balint approach in one VTS group have for course organisers and other educators who wish to put it to work?*

We ask: 'What can the case studies outlined here tell us about realising the deep learning that is central to group work, and Balint training in particular?' We see deep learning opportunities as those that seek to penetrate obscurity rather than focus on predefined tasks (though we hope that they leave some room for mystery too).

As befits an exploratory methodology and the complexity of the learning process, our conclusions are suggestive more than categorical. However, acknowledging the current imperative of policy makers to relate research to specific actions, we identify the implications of the insights gained from this study for supporting learning. We hope this complements the essential process of readers drawing their own conclusions from the data and applying it to their particular contexts.

Theme 1: what was the learning climate in small groups in GP vocational training? How was it being put to work and understood?

Care was taken in both groups to create a climate that fostered trust and a sense of belonging amongst its participants in talking about difficult consultations. The formal choreography at Highville enhanced this process in many ways, protecting case presenters from being quizzed by others in the group, allowing their story and their understanding of it to emerge. There is little point in exploring difficult areas of experience without the wisdom and structures to support the results.

But there's always a price to pay for belonging. The social glue that strengthens professional community may also make a genuine democracy of voices harder to achieve. Collaborative work was promoted within the groups and this was one of their strengths. Certainly doctors trusted sharing some aspects of their working lives with the groups. However, it became a weakness when collaboration became synonymous with consensus that could stifle questioning and debate. There was still a hierarchy of knowledge and opinion, driven into the background but still directing discourse in subtle ways. Moreover, learning from practice takes place within a world that is increasingly in the public eye and within accountability structures designed to regulate rather than teach. In these conditions it is difficult to know and trust just how private and safe a group can be. Still, in training, there was much at stake for doctors whose futures often lay partly in the hands of group leaders. Understanding the delicate interplay between self and organisational culture requires an aesthetic sense, not a thermometer. Increasingly it may also require assurances of confidentiality and privacy, so that risks taken in order to learn remain within a professional, educational conversation.

We ask:

- Are the terms and conditions of participation within the group clear, negotiated and negotiable?
- What assurances can be offered to doctors that in taking risks for their learning, they are not risking or damaging their futures?
- What feedback is provided, individually or within the group?
- How much control can the group exert over what happens and how?
- Are there processes in place to ensure that the group is run democratically and the facilitator is in the role of neutral chairperson – as promised? More significantly, is the behaviour of the group and facilitator consistent with the assurances offered?

Even with assurances and process in place, the dynamics of learning have a life of their own, as we describe in our next theme.

Theme 2: what were the dynamics of learning in a small group, and how might the Balint approach affect them?

There are a number of interrelated elements as follows:

Process is what happens all the time

It is clear that the small-group work discussed here is an ongoing process, not an end-product. Like all deep learning opportunities it is uncertain of outcome: a lifetime destination rather than a set of clearly prescribed steps along the way. It was the invitation to go through one more door, to cross one more threshold, that mattered. Process is an outcome of what doctors continue

to do throughout their lives, to gropingly discover what they need to know.

Professional development and professional socialisation

Doctors' stories suggested both creativity and constraint. The groups both encouraged doctors to question their roles in general practice, and reproduced the professional culture of which they were a part. The narratives elicited produced order as much as the freedom to roam imaginatively. In '*disturbing*' in the best sense, it did not prevent doctors from getting on with their lives with a working assumption of stability.

Tacit learning

Learning in the groups was caught as much as taught. It did not fit the steady-accumulation model of propositional and skill-based learning. It moved through complexity with partial understanding, allowing for later returns. Thus progress was uneven, fitful rather than linear, a shaft of recognition here, incomprehension elsewhere, as doctors discovered the tension between wanting to act well towards others and the difficulties of doing so in practice. While Balint training stresses the importance of not thinking in boxes, the study showed how difficult it is to do otherwise.

Learning was elusive

Most doctors valued the group experience and felt they benefited from it. However, their responses were complex and contradictory; they debated within themselves. It was possible both to value the approach and to be occasionally bored by it. Given the unfathomable nature of others' private states and the instability of 'attitude', there was no point at which an evaluator could say they had acquired this or that quality as a result of the experience. Though doctors offered self-testimony about how they perceived that the process had helped change them, whether they were actually more open to new ideas or more sensitively attuned to their patients can only be answered intuitively, not empirically. However, studying their decision making and practice over time might illuminate shifts in their understanding and practice.

Balint teaching was an important, but not the only, influence on the VTS that we examined. Learning was a continuous process of borrowings and interminglings, rather than a discrete package whose impact could be isolated. End-points and start-points are the arbitrary creations of others. The success of group work lies in the extent to which it beds into what is already there, and several examples of this were evident in the study. The strength of Balint work is that it is not, and never has been, uni-directional.

Theme 3: what might be an appropriate methodology for evaluating small-group work on the VTS?

How can we judge the worth of small-group work?

Using an ethnographic approach was an unexpected outcome of the research that had originally sought to develop an instrument to measure the difference between Balint and non-Balint groups. Like every methodology it has limitations as well as strengths. Without studying Balint training in the context of an entire VTS programme, its findings are provisional, its analytical reach modest. Moreover, research that does not also explore patients' responses to their Balint doctors can only remain partial.

Nevertheless, we suggest that the richly textured approach adopted here may be better suited to studying the dynamic nature of deep learning than conventional comparative methods. Importantly, the stories presented here can actively inform practitioners' work, rather than merely illustrate it.[47] We cannot offer conclusive proof that any one approach is better than another. A more realistic reading can encourage the curious (or sceptical) course organiser and medical educator to take a look and ask 'How would this work on my patch? What can I capitalise on, and what do I need to trim to get it to take?'

What are the limits to the judgements made in this study?

When research moves between description and interpretation, things start to happen.

The politics of meaning impact upon the research process; some views inevitably carry more power or persuasion than others. For the project team, different professional backgrounds brought with them alternative ways of knowing and determining worth. Building upon the strengths of each perspective, the study suggests that:

- Tacit knowledge is precisely that which cannot be measured.
- The short-term language of effectiveness and tangible outcomes often favoured in educational research is likely to mislead. There is little virtue in studying change in too short a time frame to capture it.
- Change is complex and lends itself poorly to simple impact measures or satisfaction scales.
- Change agents need to be studied as much as those needing to be changed.
- Too narrow a preoccupation with the *effects* of an initiative detracts from efforts to realise more of the potential of the group *experience*.
- Much might be learnt from studying Balint groups in different contexts.
- If we want to understand the Balint influence, we need to pay less attention to what is distinctive about it and concentrate on the receptive properties of the context in which it is to be practised.

Theme 4: what else was happening in the small groups under study and with what possible effects?

The question 'What else was happening?' turns out to be a daunting one, and our research can only offer some pointers. Balint works primarily at the individual level. The case studies have illustrated the many creative moments in doctors' stories and the emotional freshness that made them new. But an educational focus on experience always risks lapsing into an unproblematic

vehicle for self-affirmation and self-consciousness. We suggest more is needed.

The limitations of group work, in part, reflected deeper cultural problems. Doctors do not learn a way of life unscaffolded; culture plays a key role in creating and shaping experiences and their meanings. By this we mean the capacity to reflect upon how our experiences are inexorably shaped by the social and historical circumstances we live within. For example, it would have been unlikely that feminism, ageism or disablism would have registered as important aspects of group interaction in early Balint work.

Almost invisible were the collective defences at work within the group. Focusing on the doctor–patient relationship divorced from its institutional and social moorings risked losing sight of the way that personal troubles are always also public issues. The richest learning is not that of pure self-examination only. It is one that places the cultural assumptions of the learner and the learning process in question, so that doctors may see their own cultural practices in comparative context.[48] One way to identify how social and historical influences shape group work is to be more sensitive to the silences in reporting experiences and reflect upon what is talked about and why.

We have seen what a Balint approach in small groups might and does offer. In conclusion, we turn briefly to the key imperative animating the research, one that Michael Balint might himself have relished. How might we define the contours of this 'something' we were variously engaged in?

Theme 5: how was the Balint approach variously understood? What were the differences that make a difference?

The preliminary study's task of defining the contours of Balint work for comparative purposes was an important step in making sense of the world. Getting just the 'right' amount of difference means distinguishing between what Balint cannot afford to lose and what it cannot afford to keep. Important questions of cultural integrity are at stake.

However, the dynamic nature of group work showed that the notion of traditions as fixed, homogeneous wholes, enabling clear distinctions to be made between intervention (Balint group) and control (non-Balint group), was an oversimplification. Tradition, in part because of its local variation, is pliable and emergent. Not only were there many subtle variations in the practice of Balint groups, but also we had barely begun to unpack the complexity of 'non-Balint'. We had the right question, but not the right *research* question. There were lessons to be learnt about conducting research with different approaches to the research process.

The case studies have also shown that doctors were not empty vessels waiting to be filled by an external stimulus (an imprinting model); they were active agents with intentions and expectations, creatively interpreting what Balint was. Rather than being 'diluted', as GPs in the research team feared, there was every indication that Balint work was being reinvigorated to fit the demands of contemporary general practice. The research suggests that every Balint group is inevitably an interpretation, necessarily filtered through the lens of contemporary thinking and policy developments. This was culture-at-work.

We have seen that, via a powerful choreography, the groups articulated key values that inform the doctor–patient relationship. The question remains: without a clear unifying theory, can Balint still retain its identity? Armed with such a theory what scope for development could there be?

The research suggests that trying to pin things down too tightly may be a mistake. Symbols are effective because they're imprecise. If Highville wasn't *'a pure Balint group'*, perhaps such a quality is always beyond one's reach, like the pianist trying to capture the essence of Mozart for an audience whose ears are accustomed to Beethoven and Mahler. Can questions of differentiation and definition ever be finally resolved? Perhaps Dr Malek best sums up the spirit of Balint more as imagining than essence: a question of complexions and shades rather than a precise diagnosis. It presumes a common content, and couldn't continue to function at Highville without doing so. But it develops intuitively, allowing doctors to imagine it in terms of their own personal life projects. Living in the light of an ideal must always be more subtle and complex than simply conforming to it.

Balint practitioners are well aware that there are always more questions than answers. Similarly, as our methodology argued, ethnography starts with open questions that become focused and reshaped as the research process unfolds. The Balint approach has traditionally analysed doctors' puzzles with their patients in terms of psychological defence mechanisms. If Balint is to be of contemporary relevance, what is the interplay between psychological and collective defence mechanisms? This study has suggested that neither can be pursued in isolation.

So, these are the questions that we end on and that we hope will stimulate further research:

- At their best, educational initiatives hope to strengthen the capacity of learners to critique the situations in which they find themselves and determine new ways of acting. Can Balint work enable this kind of radical thinking? How far might Balint work join hands with other humanistically inspired initiatives within medical training and what might it become in the process?
- How far can narratives in group work be used therapeutically without drifting into therapy?
- Is the Balint process an instrument of social change as well as open to change itself?
- When every tradition is plural and differentiated, how far are Balint practitioners at ease with the subtle diversity within, as well as without?
- Whilst identifying degrees of 'Balint-ness' amongst VTS groups can answer the 'Who are we?' question, can it also address the 'Where are we going?' issue?
- How far can, or should, Balint educators challenge the more reductionist approaches to educational research that seek to rank individuals and institutions against one another?
- How might a better understanding of the doctor–patient relationship, and of doctors themselves, also

speak to the key social, moral and political issues of our time?

One person's work is always part of a continuing narrative. Education in general practice is not a game about 'winning' or proving superiority between one approach and another. Rather it hopes to prepare professionals for a complex and ever-changing role in an unpredictable context as well as to pass on culturally important values. Balint's enduring contribution to VTS training may best resemble that of a game of cat's cradle: of figures that can be passed to and fro between many players, each of whom adds new moves to the intricacy of the patterns. In this, it speaks to the best in us.

What next?

This study raised fundamental issues about how learning in small groups is experienced and how it might be enhanced. These issues require further study to inform the development of learning and teaching in small groups. We have raised some of the questions to be explored in Section 5 and here in Section 6. These all point to the importance of understanding not only the potential of small-group work but also its limitations. That insight may be identified by further studies but, to have impact, it must be developed by the participants of small groups themselves. In other words, if learning in small groups is to be maximised, participants will need to be more questioning and reflective of the process they are engaged in.

Conclusion

Learning from actual practice is vital to the preparation and development of general practitioners. Frequently, it is an uncomfortable and even threatening process. In focusing upon the doctor–patient relationship, Balint invited an examination of troubling everyday practice and offered a structure within which to learn from it. In this study we have examined the utility of that approach, in the context of small-group work in vocational training. In doing so, we looked afresh at the intentions of course organisers, the facilitation of small groups and the experience of GP registrars. Both course organisers and registrars valued examining real practice. However, the challenge of making the experience an educational one remains complex.

Assurances of openness, safety, supportiveness and trust are readily offered in the hope of enabling doctors to look at the uncomfortable, puzzling, irritating and unfamiliar incidents in real practice. These assurances are more easily offered than provided, and we explain why. In Sections 5 and 6 we identify limitations to the openness of the learning climate in the small groups, how they arise and what other course organisers might need to consider in order to avoid them. We also identify the educational potential of small-group work and how this can be strengthened. Like Balint, we can only raise awareness about key issues and not provide solutions to those issues, which will be context dependent. Additionally, the study examines the challenge of determining the educational worth of an initiative when the focus is upon learning and how that is valued. That is a rather different endeavour from measuring performance management categories, such as cost-effectiveness or stress reduction.

Perhaps the most valuable insight from the study is the portrayal of small-group work in action. We hope that readers will find illuminative instances from this that will help them to reflect on their own practice.